Delirium: assessment and treatment of patients with cancer PART 2

Delirium: assessment and treatment in the patient with cancer PART 2

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Abstract

Delirium at the end of life may present significant ethical dilemmas in clinical practice: whether to simply treat it in order to maximise symptom relief, with the resulting side effect being palliative sedation, or to attempt to reverse delirium and risk prolonging suffering. Determining whether the delirium can be reversed involves comprehensive assessment using established tools, which may or may not provide the answer to the question posed. This article examines the evidence surrounding several assessment tools that have been suggested as effective in identifying delirium, and the consequences of various approaches to the management of delirium in a patient with a cancer diagnosis. It also considers the impact delirium may have on the health professional and those close to the patient.

Key words: Delirium ■ Evidence-based nursing ■ Quality of life

■ Palliative care

There is an abundance of assessment tools available that are specifically designed to recognise the onset of delirium (Pisani, 2015). It might be considered, therefore, that delirium should be easily recognised.

As discussed in part 1 (Hardy and Brown, 2015), this is not, in fact, the case. Delirium may present alonside a diverse range of symptoms, which can confuse health professionals in identifying its cause and it also presents with traits extremely similar to that of dementia (Weinrich and Sarna, 2006; National Institute for Health and Care Excellence (NICE), 2010).

Discussion of assessment and management of delirium has primarily focused on the elderly with predisposing infection or patients that are in the immediate post-operative phase (Weinrich and Sarna, 2006).There are a number of questions surrounding management of delirium (also referred to as acute confusional state) but delirium at the end of life may be a separate entity—a suggestion lent weight by the fact that NICE (2010) specifically omits end-of-life delirium from its guidelines and pathways.

There appear to be two clear approaches to managing delirium for cancer patients at the end of life. One encompasses attempts to reverse and treat the pre-disposing factors, such as constipation and infection, followed by the use of gentle antipsychotics if the delirium is unresolved. The other is the use of medications to ensure the relief of distress, but without purposeful sedation.

Delirium-focused assessment tools may be under-used in clinical environments but could present a solution to managing the symptoms of delirium. Issues surrounding the use of any tool include when to apply it, The optimal frequency for assessment of delirium and whether it should be repeated

(Pisani,2015). There are several tools available but choosing the most appropriate one for use in palliative care could prove difficult.

Following the recognition of delirium, treatment should be instigated but this may also present significant clinical dilemmas and issues for the patient, the family and the health professional involved. Ensuring that the patient is at the centre of all decision making should be the priority, allowing them to make choices regarding end-of-life treatment, which includes palliative sedation (Department of Health (DH), 2008).

Assessment tools

The Mini Mental State Examination tool (MMSE) is one assessment tool that could be used to help in the diagnosis of delirium at the end of life for cancer patients. It is a simple test that could be used for all high-risk patients and may help distinguish early stages of confusion. The MMSE is primarily used as an initial screening tool when assessing a patient's ability to make decisions. This is followed by a more comprehensive tool completed by trained professional raters. What must be considered when using this tool is that the patient completes simple arithmetic and needs to be able to read and write—it is not uncommon to interact with patients who may find this difficult owing to established disabilities, or people that do not have English as their first language (Weinrich and Sarna, 2006). This may affect the validity of the outcome.However,it could be argued that the rater should be trained to assess for such variables.

To ensure that assessment tools are appropriate for use they are measured against the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Brown and Degner,2001),which was initially developed in 1952.The purpose of the DSM is to provide a baseline for the standard criteria of any diagnostic tool (Trzepacz et al, 2001). The previous edition, DSM 4, was reviewed and criticised for its lack of scientific evidence but praised for helping to standardise the diagnosis of psychiatric conditions (Marshall et al, 1999). The latest edition, DSM 5, has been significantly revised as a whole; it has been developed by using research and statistical data from hospital environments.With the DSM5 now in use, it may mean that the tool is more reliable and/or easy to use which will help to improve the assessment quality.

The Confusion Assessment Method (CAM) is another assessment tool that may be adopted for the assessment of delirium in the terminal phase of life (Brown and Degner, 2001). It has been tested for validity and reliability, scoring in the range of 90-100% for accuracy in sensitivity and specificity (Meagher et al, 2001;Waszynski, 2004) and found to correlate well with the DSM 4 and MMSE, but does not assess for severity of symptoms (Brown and Degner, 2001; Waszynski, 2004).This tool is effective for patients with terminal delirium as it is brief, therefore giving prompt indication of delirium (Brown and Degner, 2001;Waszynski, 2004).

The Delirium Rating Scale-1998 (DRS-98) was initially designed for the assessment of delirium in a variety of diagnostic cases and was developed byTrzepacz in 1988.This tool has since been established as an effective tool for use in the assessment of delirium in patients at the end of life (Brown and Degner, 2001). The DRS-98 is time consuming as it requires consideration of past medical history, nursing observations, tests and patient interviews, it is for this reason that extra training may be required to complete the assessment.When comparing the DSM-98 with other tools, for example the CAM, although CAM is quicker and relatively simplistic, it only assesses for actual symptoms and not the severity of symptoms whereas the DRS-98 does assess for severity, but its drawback is the complexity, and it has been found difficult to use for reassessment throughout an

episode of delirium (Trzepacz et al, 2001). It could be concluded that the poor efficacy of delirium assessment tools is multi-factorial. Inconsistency of assessment is a major aspect as no one tool encompasses all arenas of delirium so it may require the use of more than one tool to accurately recognise, assess and treat the onset of delirium for a cancer patient at the end of life. Although the tools have been identified as useful in assessing for delirium, identifying the severity is deficient in many cases. To aid effective management of patients presenting with delirium, information and advice surrounding treatment of the delirium would help and ascertaining whether it is reversible would undoubtedly expedite patient treatment as one could focus on treatment rather than type of delirium.This may help to ensure individuals receive appropriate treatment and reverse the delirium providing there is time to reverse the presentation. Delirium at the end of life carries other issues, one of which is ethical debate about suffering whilst waiting for full assessment and treatment initiation.

Ethical considerations: the use of medication when managing delirium

Evidence-based practice is a requirement in nursing practice (Nursing and Midwifery Council, 2015) however, the majority of the evidence base to date appears to focus on general adult nursing care and does not specifically relate to delirium at the end of life for a cancer patient .The need to identify reversibility remains important in end-of-life care (Twycross, 1997; Payne and Turner, 2008 NICE 2015), but in certain cases, e.g. where death is imminent, it may be that addressing reversible causes may prove inappropriate. Deciding if the delirium is reversible or irreversible alone can be an ethical dilemma as valuable time may be wasted during the investigation and Whilst potentially leaving the patient suffering. Where time is limited and success unrealistic then one may suggest that controlling should be the practitioners goal. There are recommendations and suggestions within the literature (Regnard and Kindlen, 2002; Payne et al, 2004): the need to ensure the patient is orientated to day, time and place, facilitation of distraction therapy and, if necessary the use of medication.

A search of the Cochrane reviews for evidence to support medication selection reveals there is still a lack of specific treatments for specific patient presentations (Siddiqi et al, 2007; Lonergan et al,2007;Overshott et al,2008;Lonergan et al,2009). The systematic reviews report insufficient evidence to suggest efficacious regimes, especially in end-of-life care. They have identified that the use of benzodiazepines or antipsychotics for delirium should be administered with caution as the effects of the drug can differ greatly depending on the cause of delirium (Meagher and Leonard, 2008). A general side effect of some antipsychotics and benzodiazepines is sedation. In clinical practice it has been suggested that this side effect may be of some benefit alongside treatment of the delirium for patients with the refractory symptoms of delirium, often referred to as palliative sedation (Payne et al, 2004) but the use of palliative sedation may be rejected in many areas offering palliative care to patients due to the ethical dilemmas involved—especially in light of the review of the Liverpool Care Pathway, which found sedation and opiate analgesia being used inappropriately in some cases (Neuberger et al, 2013).

Palliative sedation alone presents ethical dilemmas, but a pertinent issue that must be discussed is how people perceive palliative sedation. It is considered by some to be an indirect form of euthanasia (Payne et al, 2004; Rietjens et al, 2009). In Rietjen et al's (2009) study doctors in the Netherlands who had experience caring for patients at the end of life answered questions regarding

how they responded to patients' suffering from refractory symptoms. The majority reported that they would be happy to administer palliative sedation to patients within the last hours of life. But when they were asked if they would consider this intervention to those in the last weeks/days of life, a debate was initiated as they queried how to predict if a patient was in the last weeks of life.

Full and frank discussion with patients approaching the end of life or those who have advanced life-limiting disease may help to alleviate and clarify these ethical dilemmas regarding treatment by involving them in the decisions surrounding sedation at the end of life. It is also important to try to use other methods of managing delirium before resorting to sedation.Keeping patients involved,empowering and facilitating autonomy is fundamental to health service provision and has been highlighted as a significant goal in high-quality end-of-life care (NICE, 2004; NICE, 2011; DH, 2008; Brown andVaughan, 2013; NMC, 2015).

There are arguments for and against the use of medication to manage delirium, but it appears the fundamental issues lie with the ability to diagnose the form of delirium the patient is suffering from. Once this has been established it is possible to attempt treatment or begin reversing the symptoms (Leonard et al, 2008), but the ethical dilemma at the end of life rests on continuing to do this or focusing on comfort and quality of life (Leonard et al, 2008). It may be that making the patient comfortable at the end of life could be achieved more quickly than identifying and treating the cause.

Impact of delirium on the family

It must be acknowledged that,alongside the distress that delirium can cause to the patient and the nursing team trying to manage the symptoms, the family and patient's loved ones also report increased anguish and despair (Morita et al, 2007).The National End of Life Care Strategy (DH, 2008) was initiated to promote high-quality end-of-life care and heighten health professionals' awareness.What it did not specifically do was refer to the needs of the family when symptoms are perceived as distressing,such as pain, nausea and vomiting or delirium (DH, 2009; 2011; Smith et al, 2012). Although there may be some issues surrounding diagnosis of terminal delirium or agitation, it continues to be reported as a common complication at the end of life for cancer patients (Morita et al, 2007). Morita et al (2007) approached 560 bereaved family members of cancer patients who developed delirium during the last 2 weeks of life and this resulted in 402 responses (75% response rate). The Japanese study specifically reviewed the impact of delirium from the families' perspective. They reported significant issues such as the family feeling a failure at a critical time when they think they should be strong for their loved one.Those who were bereaved admitted to being very distressed watching their loved ones suffer with delirium and felt that professional care was lacking in managing this symptom (Morita et al, 2007). Bruera et al's (2009) study of bereaved relatives who reported delirium in their loved ones concurred and identified that family members suffered high levels of stress when recalling the symptoms of delirium. Interestingly, the researchers noted that family or caregivers reported more symptoms of delirium such as groaning, restless movement and shouting, than the specialist palliative care nurses (Bruera et al, 2009).A rationale for the difference in the number of symptoms reported by family in comparison to the nurses was that they believed family members over-interpret what they are witnessing, allowing their personal anxieties to affect their recall (Bruera et al, 2009).The nurse's recall of a patient's experience of delirium, however, was not included within the results of this study.

High-quality care at the end of life for patients with cancer: guidance and evidence

What is evident is that delirium is a significant symptom for patients at the end of life with cancer. It is also clear that the complex variances that manifest themselves within delirium are often difficult to recognise and manage. Although delirium is recognised as a problem there is very little national guidance to aid effective management on a nursing level for patients at the end of life. Despite this, there have been a number of policies released, aimed at enhancing quality of life for cancer patients (NICE, 2004; DH, 2008).

A significant policy document was the Policy Framework for Commissioning Cancer Services (The Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales, 1995) commonly referred to as the 'Calman Hine Report.' This identified that the government must implement a number of national standards to enhance the care received by patients who have cancer.Although the report predominantly focused on how to avoid advanced cancer diagnoses by using early detection and prevention strategies, rather than how to care for people with advanced cancer, it can be argued that it also laid the foundations for the governments' dedication to focus on the care that people with cancer receive (NHS, 2004, NICE, 2004, NICE 2011).

Evidence of this can be seen in the release of The End of Life Care Strategy (DH, 2008), which was primarily introduced to ensure quality care at the end of life.An outcome of the strategy was the adoption of the 'Liverpool Care Pathway' by numerous healthcare providers. This model of care was introduced as a tool to ensure that all arenas of healthcare delivering palliative care were able to meet the hospice model of care ,which was deemed the 'gold standard' (DH, 2008). It has subsequently received significant criticism, and its use has been abandoned, the principles for high-quality care for those approaching end of life remain undeniable (Neuberger et al, 2013).

Conclusion

The diagnosis of delirium may be facilitated by adopting a specific assessment tool. There are many tools available and what has been apparent is that each tool can effectively aid the diagnosis of delirium but, each tool has some degree of limitation. Primarily, the specifically designed tools required the rater to be trained in its use or they contained a significant number of questions or activities which may aggravate the patient more if delirium is present.The use of a tool may prove beneficial in diagnosing delirium, but when other comorbidities exist, e.g. dementia or depression, the efficacy of the tool may be compromised.

Practice requires development on a local and national level to ensure that every patient receives high-quality evidence-based nursing care when dealing with symptoms at the end of life.

Delirium at the end of life is a distressing symptom, but when compared to other symptoms,which may also be distressing,little research has been done to ascertain best practice in its management. It is clear that work is continually being carried out to understand more about delirium, but unfortunately, end-of-life care requires a more focused approach and the research appears generalised.

A number of assessment tools have been examined but there appears to be little agreement among researchers about which one would be effective. It was suggested that the combination of two or three tools would accurately diagnose delirium, but this could be time consuming and onerous,

exhausting the patient with questions and at times initiate inappropriate interventions. Delirium remains largely understudied with little reliable and validated research to clearly suggest and implement best practice.

Delirium can have significant impact not only on the patient experience but that of carers and loved ones. Identifying the need for intervention and providing a supportive network for all involved should be part of the holistic approach to care at the end of life. It is hoped that this discussion has provided those nursing patients at the end of life with some understanding surrounding the recognition, managment and treatment of delirium. More importantly it is hoped that this work will encourage and enthuse researchers to commence a pathway of evidence based management of delirium at the end of life for a cancer patient.

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